4 Variations on Gender and Orientation in Scott's First Interview

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Introduction

My task in this chapter is unique: to deconstruct the gender and orientation components of the first interview—how would this interview have gone if the client had a different orientation or gender from Scott, and how would it have been different if conducted by a female therapist? Because my mission is unusual, I have approached it a special way: I have literally imagined different clients and written about them here, and then analyzed the similarities and differences based on gender and sexual orientation. Moreover, I have imagined myself in Silverstein's role, envisioning how I might have conducted the interview with Scott and his "alters" differently. I have tried to focus particularly on the ways my approach would vary from his because of my gender, and inserted these observations when appropriate.

Why do gender and sexual orientation matter here? On a purely practical level, they matter because of client preference. Scott specifically requested a gay male therapist; many psychotherapy consumers want their therapist to be "like them" in some way they consider crucial, such as gender, sexual orientation, or ethnic, racial, or religious background. Although psychotherapy researchers debate the relevance of these client–therapist matches, it may be that simply *believing* your therapist understands you increases the therapist–client bond.

Gender and sexual preference also matter because there are real differences between men and women, gay and nongay clients, which will influence therapeutic assessment and treatment. For example, if a gay male couple discloses bringing a "third" into their sexual encounters, it would be helpful for the therapist to know this is a common practice among some gay men who consider fidelity to be separate from sexual monogamy and may not even define their behavior as nonmonogamous (LaSala, 2004). Likewise, gender differences can dramatically affect the therapist's assessment. An adult woman who cries throughout most of a session is not unusual, and she probably feels better afterwards. An adult male client who

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does the same is much less common—and he might feel shame, not relief, at revealing his pain. So therapists should strive to become aware of gender and sexual identity variation to better understand and serve a wide range of clientele.

What of situations where the two conflate, where it is difficult to know when a behavior is the result of gender differences, issues relevant to a gay sexual orientation, both, or neither? The ability to deconstruct gender and sexual orientation is more important than you might think in therapeutic situations. For example, we know that most gender-variant little boys—that is, little boys who want to dress up as girls, to be girls, who at times think they really are girls—do not grow up to be heterosexual males. They mostly grow up to be gay or bisexual, and a smaller percentage transsexual (Green, 1987). We have no good ways to predict which will evolve in what direction. So how does this affect what you suggest to the parents of such a child? This is a real debate among therapists, with some focusing on gender and advocating allowing these natal males to "socially transition" to female at ages as early as 6 or 7 (Lev, 2004), others viewing these boys as gay and recommending a supportive attitude toward the variant behavior as an early sign of homosexuality (Isay, 1997), and still others viewing the gender-variant behavior as pathological and attempt to eradicate it (Zucker & Bradley, 1996).

Even if you are never faced with such complex cases, you are still likely to encounter puzzles about the interaction of orientation and gender. For example, several studies have shown lower frequency of sex in lesbian couples than heterosexual couples (Blumstein & Schwartz, 1983; Nichols, 2004, 2005). Does this difference exist because women are socialized to be sexually receptive and not aggressive, so that when two women are together no one is completely comfortable with initiating? Is it because women in general have a lower sex drive than males, and if that is true, how much is biology and how much socialization? Could it be that our whole concept of how we "measure" sexuality—by frequency of genitally focused interaction, by orgasm—is a completely male perspective? Should we perhaps be "counting" sensual affection that is not genitally oriented? Are heterosexual couples having sex more because frequency is male-driven, with females seeing sex in part as marital obligation? Or, do lesbians have the special burden of internalized homophobia or female sexual shame—times two? These different explanations are important, because if the lesbian couple having little or no genital sexual contact comes to relationship therapy with you, these different perspectives will suggest a wide variety of assessments and corresponding treatment plans, often radically different from one another.

Issues around the interaction of orientation and gender are showing up both in the sexology research literature and the culture, especially lesbian, gay, bisexual, and transgender (LGBT) culture. Chivers, Rieger, Latty, and Bailey (2004), for example, used instruments that measured the biological aspects of sexual arousal and self-report to compare the reactions of gay and straight males and gay and straight females to erotic movies—pornography. They found differences along gender lines to be more salient than differences of sexual orientation. Both the gay male and heterosexual male arousal patterns appeared to be very narrow and limited

to depictions of the kind of sex they practiced. Both lesbian and heterosexual women displayed arousal not only to all depictions of human sexual interaction—gay male porn, lesbian, straight—but even to films of erotic play in subhuman primates. So Chivers' research implies that gay and straight men are sexually similar in that they narrow-focus on only literal depictions of the kind of sex they prefer. And both lesbians and straight women are alike in the broadness of their sexual arousal potential. In other words, gender may trump sexual orientation in matters of sexual "orientation." Chivers' research implies that gender differences are so hard-wired, meaning an unchangeable part of brain functioning, that they dominate whatever similarities may exist among men and women who are same-sex oriented.

In fact, some have argued that the *only* thing that gay people have in common is their sexual minority status and their shared history of oppression (Sullivan, 1995) and that when gays are truly equal they will be indistinguishable from nongays (Savin-Williams, 2005). Others have claimed a special "gay sensibility" impervious to changes in culture or historical time period (Warner, 1999).

But even if gay people have only their status as outsiders in common, that constitutes quite a lot. First, discrimination because of sexual orientation does not differentiate on the basis of gender; lesbians and gays have experienced equally bad treatment at the hands of government, military, and private institutions, and this tends to breed solidarity and a sense of "family." Second, in part because of this, gays and lesbians have tended to live together and near each other if not always evenly mixed, thus forming gay communities, especially in urban areas (Katz, 1992). During the early days of the AIDS epidemic, many lesbians, myself included, played leading roles in providing service and agitating for change. Just as Scott and his older brother share a deep bond based on gayness, so do many lesbians, gay men, and bisexuals. So it is important for the clinician to understand the special issues that affect gay people and how lesbians differ from gay men.

And some of these issues involve the intersection of orientation and gender. Modern (Post-Stonewall) gay culture has always tacitly accepted that some gay men are a little like women and some lesbians are a bit like men (Nestle, 1992). As Silverstein surmises, this intersection is the likely source of homophobia, as mainstream society is highly invested in a system of two genders with easily observable differences and relatively rigid roles. Gay culture has evolved over the last 40 years, but some forms of what is sometimes called "gender bending" or "gender queer" has always been an ever-present if sometimes controversial element. There were always drag queens among gay men—men who enjoy dressing as and impersonating women, often for entertainment. And there have always been "butches" and "femmes" among lesbians—some women who present as more male, some as more female (Nestle, 1992). More recently, the ways in which gender and orientation are morphing together are getting more complex and interesting (Nichols & Shernoff, 2006). For example, some transwomen (the term used to signify individuals who would formerly have been termed male-to-female transsexuals) are choosing to identify as lesbian after transitioning; others are living as women without gender reassignment surgery, that is, breasts, female

body and presentation, but functioning penis. Others, transmen (formerly female-to-male transsexuals) may have identified as "butch lesbians" before assuming the transidentity, but after transition find themselves attracted to gay men or other transmen. In fact, this phenomenon became common enough in the gay male community, that a few years ago the Saint's "Black Party," an iconic "circuit party" for gay men in New York, used Buck Angel, a transman, as their "poster boy"—and they featured him nude and obviously without having undergone "bottom surgery." These recent trends in the LGBT community highlight the interconnectedness of two attributes of human nature we ordinarily see as separate, gender identity and sexual orientation.

Personal and Professional Biases

Although my job in this chapter does not rely on a particular approach or theoretical school of psychotherapy, it is useful to have at least a thumbnail portrait of my general approach to psychotherapy and in particular my views about sexual orientation and gender.

My techniques are easier to describe than my theoretical views. I am often directive, I give a lot of feedback, and I tend to be self-disclosing unless contraindicated. Unlike Silverstein, I would have done more talking in the session and probably made many more supportive, warm fuzzy statements—in other words, I would have been more motherly, because as a therapist that is often part of my persona. Indeed, I sometimes think of the therapeutic relationship, especially for younger clients like Scott, as a very specialized form of relationship, part parent–child, part objective, nonjudgmental observer, some mentor–mentee, and coaching at times. My techniques are varied and eclectic, and I will mention specific techniques as they become relevant to this case.

I am deliberately atheoretical, even antitheoretical when it comes to psychotherapeutic frameworks. A theoretical orientation is perhaps helpful because, among other things, it aids in organizing and simplifying data. In truly scientific endeavor, theories are testable and rejected if the data does not support the theory. But in psychology, which deals with complex human behaviors, it is not as easy to test a specific. Even when there is data, it is subject to widely differing interpretations. So I hold different theoretical frameworks, including and perhaps especially the *Diagnostic and Statistical Manual* (APA, 2000) of the American Psychiatric Society, very lightly. I am an avid follower of neuroscience research and that has influenced me to see most client problems as a result of a mix of biological and psychosocial factors. My personal experiences lead me to view clients very much in the context of their cultural upbringing and the generation in which they have grown up.

I am a licensed psychologist and a certified sex therapist, living and working in the "queer" community for most of my life. My main area of specialization is work with sexual and gender minorities: since 1983, I have seen hundreds of LGBT

clients as well as people living BDSM/kink[1] or polyamorous lifestyles, and my colleagues at the institute I run have seen thousands more. This, of course, informs my perspective.

Because of the nature of Scott's case and the task of this chapter, my views of sexuality in general and sexual orientation and gender are clearly germane. Over the years I have developed a view of sexuality informed both by the "paradoxical perspective" of people such as Morin (1995) and the radical evolutionary biology views of scientists such as Roughgarden (2004). Briefly summarized, I believe that in the "natural" world, including humans, sex serves many functions, most of which do not involve reproduction. For example, we see in nonhuman mammals that sex is used for strengthening affiliation bonds, exercising power, and establishing hierarchies in groups, for fun, play, and so on. If this is true, the major assumption that underlies the pathologizing of sexual outliers is wrong. If the functions of sex are diverse, so should be sexual behavior and sexual orientation. It also follows that, as Morin theorizes, the drivers of sex will not just be warm and gentle, like love and connection, or even the quest for the genetic perfection, but multiple drives, some dark and dangerous, like transgression and dominance. Against the backdrop of biological influenced variations of sexuality along many dimensions, culture shapes the expression of sexuality. So, for example, in some cultures the "outlet" for gender-variant males attracted to other males is "lady-boys" (Thailand) or "berdache" (Native American) (Herdt, 1993); in twenty-first century US culture, the same personal attractions and tendencies might be expressed as transgender, gender-queer, gay drag queens, or simply gay men who make your "gaydar" go off (Savin-Williams, 2005).

I consider most of contemporary research on sexual orientation and gender identity to be fatally flawed. Most researchers are blind to the biases they bring to the table simply in accepting the idea that the goal of sex in mammals is reproduction. It is this "reproductive bias" that dictates that we somehow feel we need an explanation for same-sex behavior but not heterosexual sex, and more dangerously, it is the reproductive bias, historically upheld by Church and State, that pathologizes nonprocreative sexuality. Second, as psychologists, psychiatrists, and sex researchers, we have constructed labels such as "gay" and "heterosexual" to describe *as best we can with limited knowledge* the particular cultural iteration of phenomenon that I am convinced has existed in all times and all cultures—and then we forgot that we made up the labels, and their definitions, in the first place. In fact, not only do I believe that the categories are crude, I am also sure that there are dimensions of sexuality that are quite important that we now only dimly perceive—not just "sexual orientation" or "gender identity," but also dimensions such as fluidity versus stability of sexuality, strength of sex drive, predilection for monogamy, and need for variety and intensity in sexual stimulation.

[1] BDSM refers to bondage and discipline and sado-masochistic sex. Kink is a general term for atypical sex, such as one finds in the list of paraphilias in DSM, but without the connotation of being a pathology, only a sexual variation.

In terms of my therapeutic approach, what this means is that when I try to understand my clients, I not only look in terms of symptoms, biological predispositions, family, and peer influences, but also in the context of cultural and subcultural pressures. I look very hard at the role of gender, both biologically and culturally, and also at sexual orientation. I try to look at historical trends as well as the past to predict what kind of world my clients, if they are young, will be living in. I expect the issues of a 50-year-old gay man to be different from the issues of a 20-something gay man; the "complaints" are very culture-dependent. For example, I almost never find a young person needing extensive work to accept her or his gayness, a type of client that was common when I started in the early 1980s. And I think we see far fewer of those clients—the ones with horrible internalized homophobia—because their numbers have decreased in response to cultural shifts toward acceptance of gays. These days, I'm more likely to see a young client trying to figure out if she or he is gay, bi, trans, fluid, or gender queer.

Self-disclosure is natural to many "queer" therapists practicing in the LGBT community, as Silverstein models even before the first session, by forthrightly disclosing his sexual orientation to Scott. Many clients, perhaps especially members of sexual minorities, feel they can achieve the understanding they need only from someone who shares their sexual orientation. This is a powerful reason to self-disclose what might otherwise be regarded as highly personal information.

My first exposures to psychotherapy predisposed me to self-disclosure for other reasons. As a teen in the 1960s, I developed an addiction problem. First, I sought treatment from traditional psychotherapists. I was not helped at all, largely, in my view, because of what I saw as the detached, silent demeanor of these classically, analytically trained therapists. Later, in despair, I located what was then called a "therapeutic community," a drug rehabilitation method that eschewed traditional mental health professionals in favor of "peer counseling." I remained in this atmosphere, first as a client, and then as a "peer counselor," for 6 years. In 1973, I entered graduate school in clinical psychology deeply skeptical of my new profession. I subscribed to the "psychiatry-as-enforcer of cultural-morals" view of psychotherapy eloquently described in *The Myth of Mental Illness* (Szasz, 1961) and the "psychiatry-as-paternalistic" view outlined in Chesler's *Women and Madness* (1972).

Much of my skepticism, if not my in-your-face militancy, remain today. And, like many women who consider themselves, as I do, "feminist therapists," I believe that the power differential inherent in the traditional psychotherapy dyad should in most cases be broken down. One of the ways to do this is to *not* use the term "doctor" to refer to oneself; another method is to liberally self-disclose. This difference—the efforts I would make to shape the interview as more egalitarian, in a way—is perhaps the most obvious way my approach would diverge from Silverstein's, and I feel it is directly related to being a female therapist, more specifically someone who practices feminist psychotherapy.

In this chapter, I self-disclose for a different reason, to let you as the reader/clinician know pertinent facts of my life that might influence counter-transference in Scott's case. I have already revealed some, my own earliest experiences with

treatment and with being a counselor. In addition, I have lived an atypical sexual lifestyle, especially for a woman. Sex was an important part of much of life personally as well as professionally, and my experiences have been not only atypically numerous (again: the caveat "for a woman"; more about that later) but very diverse. I can relate to more than one of the sexual minorities with whom I work. I've been a social activist in mental health areas related to sexuality, for example with AIDS, bisexuality, and BDSM. In general, my lifestyle has been well outside of mainstream culture; for example, my female partner and I had one of the first "turkey baster babies" in the early 1980s,[2] and in addition to forming the Institute for Personal Growth, the group private practice where I still work, I was involved in founding both a feminist women's center and the largest AIDS social service center in New Jersey. I currently have a nontraditional family, which does not include any of the members of my family of origin, so I am perhaps more comfortable than many therapists with the idea that some parents are toxic and should be avoided, something that is of relevance to Scott's case.

One other event in my life affects my view of Scott and particularly my emotional response to his situation. In 2004 I lost a daughter, nearly 10 years old, who died after a difficult 3-month hospitalization following a prolonged misdiagnosis of a brain tumor—a situation not unlike the misdiagnosis of Scott's brother, David. My son was then 20 years old and extremely affected by the death of his sister, to whom he felt closely bonded. So I am a mother who lost a child and watched the sibling go through a very difficult and complicated grieving process. I have a deeper than average, and more visceral, knowledge of this kind of grief. Indeed, my practice now includes a number of bereaved parents and siblings; for example, two young men who lost siblings are in my practice now. This gives me a very special understanding, on one hand, but perhaps makes me less objective, on the other.

My life has been unconventional. I have lived and practiced for decades in a community where diversity is truly celebrated and where ideas considered so radical as to be preposterous by the mainstream are seriously debated, like the need for the death of the two-gender binary, for example, or whether sexual orientation is fluid or stable over time. That informs my assessments and methods in many ways. There is little that shocks me, and my tendency is to de-pathologize clients, sometimes too much. If anything, I err in the direction of seeing clients healthier than they may actually be. My interventions are nontraditional. If I get a client whose sexual preferences are kinky, I try to help that person get rid of their internalized "kink-phobia" instead of trying to "cure" the "paraphilia." I have occasionally suggested experimentation with polyamory or swinging to monogamous couples in therapy.

Unlike other authors in this collection, I have not been tasked with describing a particular therapy approach and contrasting it with other techniques. My job is to imagine the differences in how this interview would have been conducted, and the future directions treatment might take, first if I as a female therapist had done this, and second, if Scott had been a heterosexual female, a lesbian, or a heterosexual

[2] A term for babies conceived by a lesbian couple using a sperm donor and at-home insemination.

male. I will start with my view of Scott and how both my perspective on Scott and my interventions in the session would have diverged from Silverstein's. Then I tackle the second task. To accomplish it, I imagined three "alters" and describe them here. Finally, I try to extract general principles of sexual orientation and gender interaction that might be useful in a clinical setting. But before I describe the alters, let me summarize my view of Scott and his problems and point out how my female and feminist perspective informs me.

Scott, Through a Woman's Eyes

Scott is an easy client to like: engaging, intelligent, attractive, interesting, and personable. He is high-functioning with lots of strengths. He has no psychiatric history, a good, if demanding, job he enjoys and that pays well enough to allow him to live in an urban gay area. His plight triggers empathy and compassion, which in my case is probably connected to the fact that he is roughly my son's age. Scott could be a friend of my son's, someone I have hosted in my home. As a woman who is also a mother, I immediately have maternal feelings toward Scott, and I will probably radiate that to him in even this first session. He will see me as his mother's generation, but in his unconscious I may become the mother, his own mother cannot be for him. This transference can help our initial bonding but create complications later on in therapy.

Some of Scott's strengths have been gained from learning to survive in a highly dysfunctional and weirdly abusive family. He appears to be holding his parents together after David's death, especially his mother. However, it is hard to tell how much of Scott's success in life has depended on the support of his older brother David, now dead.

Scott is in a potentially serious crisis. He is dealing with "complicated bereavement." Just as some therapists consider any loss of a child by a parent to be by definition complicated bereavement, I would argue that often the death of a sibling at a young age—and 30 is young—is complex and of major proportions. For one thing, the death of a young person is a shock to a number of illusions we believe, illusions that are usually gradually worn away with age: that life is safe, that it is fair, that you can protect someone you love, and that you have control over your own life. Losing these beliefs may lead to wisdom; in youth, having them suddenly stripped away through unimaginable loss is frightening.

Scott's bereavement is also complicated because he was not just "close" to David. He idolized David and presents himself as being dependent on him—he even calls him "my ego." Moreover, David died as a result of HIV. Although HIV is less feared and stigmatized than it was in the 1980s, it is still seen by many, especially in mainstream society, as the result of sexual promiscuity. Scott undoubtedly sought a gay male therapist in part because he wanted to avoid this judgmental attitude, and he may have been less forthcoming about his own sexuality with a female therapist. If I were conducting this session I might have made a

point of mentioning my past AIDS involvement and the fact that I lost beloved friends to the disease.

The death of an adored brother would be a crisis for anyone. But many other issues complicate Scott's situation. First, David made a shocking deathbed revelation, which revived accusations made years earlier that their father had had incestuous, or at least sexually inappropriate, contact with both boys. Scott says his suicidal thoughts "haven't been this strong since I was a teenager dealing with the whole molestation thing" (P134), suggesting the kind of revivification of traumatic memories common in post-traumatic stress disorder (PTSD). Second, Scott implies that he suffers from "a lot of guilt," (P134) connects it to what he suspects is insufficient grief over his brother's death, and then scurries away from this issue. It is likely that Scott suffers from "survivor's guilt," especially strong in sibling survivors. Moreover, Scott has put up with ongoing financial victimization by his father, for reasons in part related to his mother. He has a strong perceived obligation to assume the role of his mother's protector and, now, apparently, he has cooperated with her in helping her stave off grief about her son David's death. Scott feels extremely close to his mother, but their familial roles seem nearly reversed.

Other factors complicate this case. Scott suffers from anxiety and suicidal ideation. He seems dependent on marijuana use, and one senses the possibility for abusing alcohol as well. Scott maintains he wants a relationship—"Of course ... Who wouldn't?" (P135)—but that is unclear. He frames his relationship problems as his poor choices—choosing men who are unavailable. But from his history, it appears he has been nearly as unavailable as the boyfriends he decries. At the point of the first interview, it is hard to assess how much of Scott's expressed relationship difficulty is psychodynamic. It is hard for me to tell how much is even really a "problem," as opposed to, for example, an indicator of his youth and generation, a valuing of career opportunities above relationship ties, or even just an aversion to monogamy. But without knowing more about Scott's relationship patterns, it is still possible to glean from this interview that his interactions with men in the last year appear both desperate and dangerous. Scott is engaging in the most high-risk sexual behavior possible, unprotected receptive anal sex with men. Scott is grappling all at once with complicated grief over the loss of an important older brother, unhealthy engagement with his family of origin, a possible flare-up of PTSD, recent risky behavior, and relationship issues. One senses that Scott has come to therapy because he feels driven almost to the edge of what he can handle, and indeed his plate is much fuller than that of the average person of his age.

If I compare Silverstein's handling of this first session with Scott to what I imagine my own might be, and compare them from the perspective of being a feminist and female therapist, what comes to mind are perhaps more differences in technique than in assessment. Like Silverstein, I might have established my "credentials" on first telephone contact, in my case as someone who has had considerable exposure to gay men and HIV, who is "part of the tribe" if not a gay man herself. But once the session began, my style would have diverged substantially, in part simply because of individual differences in therapeutic styles, but to some extent because of varying perspectives influenced by our different genders.

I would have introduced myself like this, while smiling and extending a hand to shake Scott's: "Hi, I'm Margie. It's Doctor Nichols but I don't 'do' the doctor thing." I would have invited him to partake of candy, cookies, and bottled water left in the waiting room for clients and pointed to the rest room before leaving him with the 10 minutes' worth of paperwork he needed to fill out.

When I brought Scott into my office I would have invited him to sit on the sofa and spent a minute or two in small talk: the weather, how easy or hard it was to find the office, the neighborhood in which my office is located. My goal would be that by the time I began asking difficult questions we would already have made some human connection as *peers*. This, I believe, is a fundamental cornerstone of feminist therapy: that both partners in the dyad are equal. It is not an accident that I call consumers of psychotherapy "clients" instead of "patients." The point is to de-pathologize the consumer and make the relationship egalitarian. Silverstein has done an excellent job of explaining how psychiatry oppressed gay people by pathologizing homosexuality (Silverstein, 1972, 2009). Women have probably suffered even more abuse at the hands of the mental health establishment (Ehrenreich & English, 1978). Central to this abuse was the entrenched belief that the "doctor" was powerful and knowledgeable to know what was "good" for a "patient" despite the "patient's" wishes. So it is not surprising that I, as a feminist therapist, would want to avoid establishing what I view as an unequal, hierarchical relationship with someone seeking my services.

Rather than dissect each of Silverstein's interactions with Scott, let me make some generalizations about what I might have done differently. The cookies and candy are deliberate. I am quite comfortable with the persona I project that some of my clients have described as "earth mother." I see therapy as part science and medicine, but also part village shaman or wise woman, part re-parenting, part mentoring, and part guide to one's interior life. I am comfortable with a type of transference many therapists would discourage, just as I am comfortable with a degree of self-disclosure many would avoid. So Scott would know quite early on that I lost a child and that I have a son near his age who suffered through his sister's loss. I would be much more interactive with Scott, for example, normalizing his grief reaction so as to alleviate some of his guilt, giving him lots of positive feedback about his strengths and the difficulty of the tasks he is facing now. I would establish between us the bond of those who have lost a close family member while the family member is young. I might explain PTSD as a way of helping Scott understand his "manic" feelings and suicidal thoughts, and I might even mention that I use a fast, effective treatment method for PTSD called EMDR.[3] Again, my approach stems from the idea that Scott and I are collaborators right from the beginning, and that he deserves information and feedback.

There is one specific area where my approach is directly informed by my experiences as a woman treating female clients. I would have paid more attention to the allegations of molestation. I will write more about this later, when I tackle

[3] EMDR stands for "Eye Movement Desensitization and Reprocessing", developed as a treatment for PTSD.

the concept of Scott's alters. But at the least I would have told Scott that I thought his former therapist had minimized the issue and that this happens commonly when men or boys are molested. Because of my perspective on the impact of child–adult sexual contact, among other things, I would have taken Scott's suicidal thoughts more seriously. Before he left the session, Scott might have signed a no-suicide contract with me, or at least given me a verbal promise of safety, and gotten referrals to support groups for adults abused as children. It seems to me that this divergence from Silverstein's approach is the result of my experience with issues of female sexuality and abuse, both as a woman and as a feminist therapist.

Scott and His "Alters"

The primary task of this chapter is to explore how this initial interview might have been different if the presenting client, Scott, had been heterosexual or a straight or gay woman. Having seen clients representing the widest variety possible of sex and gender expression for over 25 years of practice, I know that there are some clients whose problems transcend identity and cultural background. Scott's case is not one of them. Although some of his problems—the bereavement, the family dysfunction—are arguably mostly "universal," many of them have a particular "spin" associated with his sexual orientation and gender.

This is because many of the problems Scott faces concern sexuality—sexual orientation, sexual abuse, sexual expression, and sexually transmitted diseases. And sexual issues, perhaps more than any other category of difficulties, vary distinctly by gender and sexual orientation. So, for example, as a gay man in the twenty-first century, Scott will see HIV differently than will his heterosexual counterparts—and even his lesbian sisters. And Scott and David's sexual behavior will be judged in certain ways relative to HIV risk precisely because they are gay men. Even sexual abuse, including incest, has different meaning depending on gender and sexual minority status. So Scott's interview provides rich material for an analysis of these variables. A *very* big caveat: By definition, this chapter is all about stereotypes and generalizations. Please be aware as you read that there is more variation of most traits and behaviors within a gender than between genders, and that the same is true of sexual orientation. The broad strokes I paint here risk being caricatures; I have tried to avoid this but in some ways it is inevitable.

In order to write this chapter, I imagined three counterparts, or alters, to Scott: Sarah, a heterosexual woman; Sue, a lesbian; and Sam, a heterosexual man. I encountered my first difficulty immediately: Sarah and Sam probably wouldn't have chosen a gay male therapist in the first place, and Sue might have specifically chosen a woman. So I started my imaginary characters with the assumption that the facts of the alters' lives resembled Scott's as much as possible, and that, like Scott, they sought out a gay male therapist.

I had trouble with some of the "facts," though; for example, that Scott had had only one session in his previous therapy experience. It was nearly impossible for

me to imagine sophisticated, educated, urban women, gay or straight, not having gone into therapy for an extended period of time over the allegations of abuse that first surfaced when Scott was a teen. This difficulty is itself an example of gender differences in the treatment of child molestation. One of the legacies of the second wave of feminism was a heightened awareness of domestic violence and the sexual abuse of women, including incest and other sexual molestation of female children (Bass & Davis, 1988). Since the 1980s these have been high-visibility issues for women and ample resources and support, both peer and professional, have been developed. Similar awareness of the sexual abuse of male children has not occurred, or has occurred more recently (Abel & Harlow, 2001).

Because of this, Sue and Sarah might have handled the abuse allegations very differently when they first emerged. First, the showering episodes Scott describes would have been more likely to be seen *as* abuse, by them as they got older but certainly by the therapist they had as teenagers. Hence, both Sarah and Sue might have availed themselves of therapy and self-help groups to work through the allegations of abuse. Sue might be especially likely to consider herself an incest survivor: Lesbians are arguably the biggest consumers of psychotherapy and twelve-step programs of any sex/gender minority, and educated lesbians tend to be very informed about mental health issues (Ryan & Bradford, 1993).

In the end I decided to keep as many of the facts the same as I could, although that broke down when I got to family dynamics, which I will explain later. Before I tell you the stories of Sarah, Sue, and Sam, let me tell you how I believe being a gay man has shaped Scott's story so that you have a basis of comparison.

Scott's Narrative

The first thing I notice that marks Scott uniquely as a gay man is the way he discusses HIV. He is straightforward, matter of fact, and unashamed. While there is some stigmatization of gay men who seroconvert within the gay male community, it pales in comparison with the shame attached to contracting HIV for everyone else. HIV changed from being a terminal illness to mostly a chronic disease (for those who could afford good medical care) at about the time that Scott was a teenager and had his first sexual experience. He may not have known anyone who had died of AIDS/HIV until his brother's death, but he definitely came of age when sex was physically dangerous, and when HIV was still quite visible in the gay male community. On the other hand, *because* he may not have known men who died of AIDS, his attitude about safe sex may have become a bit complacent, which accounts for his attitude about "barebacking," or being the recipient of unprotected anal sex (Shernoff, 2005). It should be said that 20 years ago I would have seen Scott's behavior as flagrantly self-destructive, whereas I would now view it as a mixture of self-destructiveness and denial. Again, behavior must be evaluated in context; Scott's behavior, while risky, is unfortunately somewhat common, and is less risky than it used to be because HIV is so much less likely to be fatal.

This degree of riskiness of behavior also marks him as a gay man. Overall, gay men are *more* conscientious about condom use than heterosexuals; however, they are

more at risk when they are *not* conscientious. The fact is HIV isn't easy to transmit. Oral sex has never emerged in any of the many Centers for Disease Control (CDC) sponsored studies as an easy vector of transmission, and vaginal sex isn't nearly as risky as anal sex. In fact, the risk to men from vaginal sex is extremely low and for women far lower than for those who engage in unprotected anal sex, no matter what the gender. Scott has a good deal of awareness of HIV risk because he *has* more risk, at least as compared to white, middle-class, straight people.

Scott's ambivalence about the alleged childhood sexual molestation is reflective of the lower visibility of this issue among men. But one thing stands out: When asked about prior therapy experiences, Scott indicates that David's therapist normalized their father's behavior and even implied that David had sexualized the showering together because of his sexual orientation. And, although it is not clear in this first session, this therapist's opinion may have in part persuaded Scott to see these incidents as "normal," as well. Scott may have blamed himself for sexual contact, or imagining sexual contact with his father. Although he never said this, on some level he may believe these incidents turned him gay. His somewhat driven behavior with male partners in the last year may be a replication of early father–son psychic drama, a manifestation of PTSD. But at least consciously, Scott seems to have minimized the possibility of sexual molestation by his father, and David's deathbed revelation of a "circle jerk" organized by Dad has threatened his compartmentalization of this contact and triggered significant anxiety. This is going to be a significant issue for Scott, as it would for anyone, but it will be complicated in particular by his gender. Because sexual abuse of male children has so little visibility, Scott will get less support and have fewer resources than if he were female.

The fact that Scott and David were both gay makes their bond special, and the bereavement more difficult. Scott makes the men sound almost like twins. In addition, the young men were each other's family support; Scott cannot rely on either parent to support him through his grief, and there are no other siblings. Fortunately, there are good supports for HIV bereavement in the gay male community, especially in urban areas. Although there was no time to assess Scott's support system of friends in this session, it is likely that as a gay man living in a city, it is both strong and accessible.

Scott's relationship with his mother seems quintessentially gay male. Years ago the "theory" about gay men was that they were the product of overprotective mothers (Bieber, 1962). It never occurred to therapists that the mothers of gay boys needed to be protective of them. Scott's mother, although she did not protect them from abuse by the father (if indeed it occurred). She may have protected Scott and David in other ways. Mothers tend to be more accepting of gender-variant boys than are fathers, and this may be in part the source of his protection of her. The flashes of anger Scott professes are appropriate, but he seems to act from guilt rather than rationality. In addition, Scott may identify with his mother as another victim of Dad, and this may drive his "enabling" behavior.

Drug use and sexual impulsivity/compulsivity tend to be more typical of males than females, who are more likely to engage in behaviors like self-cutting or disordered eating. One would expect Scott and his heterosexual male counterpart to

exhibit these coping behaviors, and for the behaviors themselves to be somewhat normalized. The same behaviors are more transgessive for women, and thus carry different meanings.

For a gay man, Scott's sexual history is moderate; his first sex was around age 16—a friend of his older brother's—and he describes it as an unambivalently good experience. He had only a few sexual partners until 3 years ago, after the break-up of the second of his two "serious" relationships. Scott reports the number of his total sex partners to be "probably somewhere in the teens" (P94), but it is unclear how many of these encounters have involved unsafe sex. Scott's muted concern about his unsafe sex is all the more striking because of David's death and history of false negatives.

Sarah's Story

If Sarah is Scott's heterosexual female counterpart, she chose an openly gay male therapist because she is culturally liberal, expects empathy about David's death from a gay man, and understands that a gay male therapist will be nonjudgmental about HIV. In addition, an openly gay male therapist would be less likely to trigger father issues, which Sarah undoubtedly has, and a female therapist might provoke her anger at her mother. I imagine Sarah as much more ambivalent than Scott about her mother, for a number of reasons that I will explain in a while.

Because of the high visibility of sexual abuse among women, both Sarah and her lesbian counterpart Susan would have been more likely to begin therapy after the original revelations, and neither would be likely to see showering with Dad as harmless. It is very possible that both women felt some uneasiness when they were young children. Moreover, David's therapist, who apparently saw father–son showering as appropriate, would have been unlikely to normalize father–daughter nudity. Even if Sarah had not continued in therapy, there are extensive networks of "survivor" groups for women from which she could have obtained help. In fact, between the allegations of incest, Dad's gambling problem, and the propensity of women toward psychological self-improvement, both Sarah and Susan might have been involved in Gam-Anon (for those associated with a gambling addict) or Adult Survivors of Childhood Abuse (ASCA) groups. Sarah would be more likely to see herself as a victim of her father, might have a bond with Mom based on their shared abuse at his hands, and might consider herself a victim of the men she dates, instead of just someone who makes bad choices.

If Sarah was neither in therapy nor in any of these groups, I might be more worried about her than about Scott when suicidal thoughts are expressed. I assume that the degree of denial Sarah needed to counteract somewhat common messages in her environment would have been intense, and this use of denial, a somewhat primitive coping mechanism, suggests an underlying fragility. In addition, I would expect Sarah to be wrestling with more sexual shame than Scott, simply because women *have* more shame about sex than men, almost regardless of the issue. Compared to Scott, Sarah's relationships with men seem more likely to be a reenactment of the incest situation. All in all, this is a volatile situation, on top of her

losing her idolized and idealized older brother. Although Sarah would not have the bond that Scott and David had as gay men, she might have looked at David as a protector and perhaps fear she could not manage life without him. I might be thinking seriously about suggesting medication to Sarah, fearing more risk of self-harm.

But let us assume instead that Sarah availed herself of self-help groups, which, I believe, can be as effective as psychotherapy. In this case, she might have a healthier relationship with her parents than Scott. She would consider herself a "survivor," and she would be more likely than Scott to have already distanced from her parents, emotionally if not literally. In fact, Sarah might well have sponsors in her ASCA program urging her to cut off her "toxic parents." Sarah might be angrier with Mom for not having protected her from incestuous contact with her father, because, unlike Scott, Sarah has no ambivalence about whether the contact was inappropriate. Sarah is likely to consider Mom an "enabler," a paradigm that would fully justify Sarah's pulling support from Mom and no longer shielding Dad. Sarah might have decided not to prosecute her father for his last credit card fraud act against her, but she would be unlikely to continue this behavior for long. The deathbed revelation would have a less-disturbing impact on Sarah because she has already come to see her father as a sexual abuser, and so in the long run the disclosure will be less shocking to her. I would be less worried about her than I would be about Scott, especially if, as is likely, she has a support system in the self-help community so-called "sexual abuse survivors."

Sarah's sexual history has a different meaning because she is a woman, as well. While it may not be unusual for a man, particularly a gay man, to have had partners "in the teens" at age 30, it is substantially above the national average for women: for females aged 30–44, the average is four (Laumann, Gagnon, Michael, & Michaels, 1994; Peplau, 2003). Arguably, the average is probably a bit higher for single, urban women, and certainly Sarah's "numbers" don't suggest sexual addiction or obviously self-destructive behavior. Sarah may be more sexual than the average woman—but she may also be acting out the incestuous behavior. Certainly, she is more likely to have some shame attached to her behavior, even in this age of *Sex and the City*, and she would not have accepted so easily Silverstein's assertion that the amount of her sex was "not a lot." Moreover, since Sarah is not gay, I imagine her having her first sex with a straight male friend of David's and see it as more significant, because 16-ish is a big young for a straight girl to have intercourse (average age is 17.4 years for girls, Laumann et al., 1994), and having sex with someone that much older is also unusual. So from the start, there is something different about Sarah's sexuality.

Perhaps what differentiates Sarah from Scott the most is HIV. The data shows that heterosexuals are far less likely to be concerned about safe sex than gay men or lesbians. According to the CDC, less than one-third of sexually active heterosexual youth use condoms (Shaw, 2010). Indeed, the term "safe sex" is a gay term, used by gay men and lesbians but not much by heterosexuals. In part, the lack of concern about HIV is a reflection of reality. So for Sarah, what constitutes "unsafe" or "risky" sex is possibly the lack of birth control, and if she is using birth control

but not a condom, she is likely to be afraid of contracting genital warts (HPV), not HIV. Sarah would probably be surprised at Silverstein's concern about HIV, even with David's history of false positives. And I would view Sarah's behavior, not as an unconscious death wish, but rather perhaps a wish to get pregnant and sabotage her career, or perhaps a way to enact an unconscious psychodrama involving her father.

Susan, Scott's Lesbian Alter

If it is difficult to imagine Sarah not seeking therapy 12 years earlier for incest allegations, it is even more difficult to imagine this for Susan, because awareness of abuse is so prominent in the lesbian community. Susan's choice of a gay male is unusual; lesbians tend to want female therapists, no matter what their orientation (Ryan & Bradford, 1993). So I imagine she is seeing Silverstein because she has gay male friends and experiences gay men as less judgmental about sex than women. As a lesbian revealing unsafe sexual practice, she might be acutely aware of the possibility of being judged.

Because it is so hard to imagine Susan as an educated, urban lesbian *not* seeking therapy for the incest, I will assume that she has availed herself of the sexual abuse survivor self-help groups ubiquitous in the community. The LGBT Center in New York, for example, houses numerous sexual abuse recovery groups, incest survivor groups, and ASCA groups, but only one incest survivor group for men. Susan, like Sarah, would be more likely than Scott to see showers with Dad as incestuous behavior, to have had clear validation from the lesbian community, and to have resolved it. She may have gone through a period where she had worries that Dad "turned her gay," but she might not care. As a lesbian survivor of father–daughter incest once said to me, "if he turned me gay it's the only good thing the son of a bitch ever did for me."

In general, Susan would be more like Sarah, her heterosexual sister, than Scott, her gay brother. This underscores a theme that I will return to repeatedly in the remainder of this paper: where women are concerned, gender often trumps sexual orientation. So, like Sarah, Susan is likely to have resolved more issues about early sexual molestation than would Scott, and thus less likely to have been thrown into crisis by David's deathbed revelation. Unlike Scott, she would not be ambivalent about whether abuse occurred, she would probably be angrier with both her mother and father and less enmeshed in their dysfunction.

Therefore, Susan is probably ready and willing to ditch the family. Many lesbians and gays have suffered at least temporary estrangement from their family of origin (LaSala, 2010), and thus create nonbiological families composed of ex-lovers and friends. Susan probably has a community to support her, feels much less need for parental relationships in general, and would find a great deal of support for cutting off her relationships with both parents.

If Silverstein's client was a lesbian, her biggest issue might turn out to be her sexual behavior and "unsafe sex." Susan, like Sarah, is a sexual outlier; few women are as sexual as she. She was young to have her first sexual experience and she has

had more sexual partners than the average woman, heterosexual or lesbian. What does Susan mean by unsafe sex? Lesbian sex is safe to begin with. Ironically, from the beginning of the HIV epidemic, lesbians have been more vocally concerned about HIV than heterosexuals, while at the same time being the lowest risk group. In fact, there are only a few case reports of woman-to-woman HIV transmission, and most of those cases have other risk factors as well (e.g., IV drug use). But while lesbians turned out in great numbers to lovingly care for their dying gay brothers during the first 15 years of the epidemic, they have tended to be if anything overly cautious about safe sex. And, correspondingly, lesbians can be very judgmental of other lesbians who contract HIV—especially if their exposure was through having sex with men.

As a therapist, Silverstein would have questioned Susan more about her assertion that she has had unsafe sex because her definition of safe/unsafe is not immediately obvious. Given the views about sexual safety that are prevalent in the lesbian community, Susan's statement could have signified her participation in two types of activities:

1. Sexual behaviors that are considered unsafe among lesbians but that in reality are not very dangerous. Susan might have not used condoms on sex toys or sterilized the toys; she might have had sex while she or a partner were menstruating; she could have had oral sex without using dental dams. She may have had sex with bisexual women. If this is the kind of activity Susan is worried about, it might be prudent for the therapist to allay her anxiety with facts. I would have done so, and I might further have encouraged Susan to get an HIV test, making certain to tell her doctor about her brother's tendency to test false negative. But I would not be particularly worried that Susan was HIV positive. The suggestion would be primarily to promote her peace of mind. Susan came to see a gay therapist because she knew he would neither be unduly alarmed nor judgmental about this "unsafe" sex. But the "unsafeness" of her sex would not be something Susan's therapist would be focusing on a lot in future sessions, except as a psychological issue—for example, if she believes these behaviors to be risky, even if they aren't, why is she doing them?
2. Susan might mean something entirely different when she calls her behavior "unsafe." She may mean that she's been having unprotected sex with men while living as a lesbian-identified woman. This behavior would put Susan at about the same level of risk of contracting HIV as Sarah, unless Susan is sleeping with bisexual men. Susan's therapist might have more concern about pregnancy than about HIV. In fact, if this were Susan's revelation about "unsafe sex," the entire focus of treatment going forward would change. Besides the obvious crisis issues of PTSD, suicidal ideation, and complicated bereavement, Susan has another very big problem. She is a self-identified lesbian, living in an urban lesbian community, but sleeping with men. Susan, at age 30, grew up in the age of "LUGs," or "Lesbians Until Graduation," the humorous, slightly negative term used to describe the prevalent bisexual experimentation among college-age and 20-something women and the sometimes fluid sexual identity that younger women exhibit. Diamond (2008) has followed these women and finds that they tend to change sexual orientation identity as they change the gender of their partner.

The problem is that bisexuality has been a divisive issue in the lesbian community for years. As Paula Rust (1995) observes in a study of lesbian attitudes toward

bisexuality, "there are a variety of images, both positive and negative, but the negative far outnumber the positive" (p. 93). So if Susan is lesbian-identified and having sex with men, she is likely to be secretive about this and hide it from her lesbian friends for fear of what could be almost a "shunning." Not only will Susan be coping with identity issues, she is probably fearful of being an outcast among her friends if her behavior is revealed, especially if she is not using condoms with her male partners. In this scenario, Susan risks being stigmatized as a "carrier" for HIV, and her opportunities for female partners would drastically decrease. If Susan is having unprotected sex with men, then the dominant treatment themes going forward would be: the health risks of her behavior, primarily pregnancy or non-HIV STDs; the meaning this sexual behavior has for her identity; and the potential for loss of her support system.

If Susan is estranged from her family of origin, which she is more likely to be than Scott, the loss of community could be devastating. One of Silverstein's interventions might well be to encourage Susan to attend the numerous bisexual support groups that exist in most urban LGBT centers. Realistically, she might lose support from lesbians and ultimately she might feel more comfortable with other bisexuals.

The issue of relationship avoidance would be a bit different for Susan as well. Silverstein would be well advised to encourage Susan, like Sarah, to explore her obviously ambivalent desire to be in a monogamous relationship. Susan is a woman, and has been socialized or predisposed to prioritize relationships over individual achievement, to believe that sex is moral in the service of romantic love, and to feel she is not "complete" without a partner with whom she lives in monogamous commitment. To that extent Susan, like Sarah, probably experiences more shame about her sexual behavior than does Scott. So Silverstein will want to explore how much Susan's ambivalence about having a relationship implies difficulties with intimacy or just a desire to remain unattached. Silverstein should validate single-hood as a viable lifestyle; among women (and some men), being single is what happens when you are in between relationships. And he needs to challenge her assumption of monogamous commitment.

There are many forms of nonmonogamy (Taormino, 2008). It is most common among gay men: nonmonogamy was accepted decades ago by most male couples (McWhirter & Mattison, 1984) and the incidence did not really decrease even after the HIV epidemic (LaSala, 2004). Forms of nonmonogamy became visible among heterosexuals briefly in the 1970s as "open marriage" and "swinging" (O'Neill & O'Neill, 1984), but then became subterranean until they resurfaced again, facilitated by the Internet, in the form of the polyamory movement sometime in the 1990s (Anapol, 1997). Similarly, nonmonogamy was promoted among lesbian-feminists in the 1970s and early 1980s (Vance, 1984), only to lose visibility and later reemerge as polyamory (Munson & Stelbourn, 1999). The difference between polyamory and other forms of nonmonogamy is that "poly," as it is called, implies emotional attachment as opposed to purely recreational sex, and sometimes even involves group marriages. It is more suited to many women than are the more recreational forms of nonmonogamy practiced by most gay men and swingers. Gay men rarely consider themselves "polyamorous" and are infrequently found at

"poly" events. And even though most people who consider themselves "polyamorous" are heterosexual or bisexual, the average heterosexual is unlikely to know of this community (Nelson, 2010). Lesbians, on the other hand, have always had a small but visible contingency of "sex radicals" (Nichols, 1987) and sexual issues tend to be openly debated. Thus, paradoxically, while Susan might face harsh censure from some lesbians if she has sex with men, she also has easy access to support groups of bisexual women and those who practice alternative lifestyles like polyamory (Munson & Stelbourn, 1999; Taormino, 2008). Susan probably already knows some lesbians experimenting with open relationships and the poly lifestyle could be at some point a potential resolution to her conflict between desire for intimacy and desire for independence.

Sam, the Heterosexual Male Alter

Sam, the heterosexual male younger brother of David, a gay man, undoubtedly overcame his own internalized homophobia years ago in order to be so close to his brother. He is therefore likely to be quite comfortable among gay men and to seek a gay male therapist because Sam would assume that such a therapist would be nonjudgmental, particularly about both HIV and unsafe sex. If Sam refers to "unsafe sex," he may mean condomless sex with a female partner. If this is the case, Sam is at low risk of contracting HIV, both because women who are not IV addicts or the partners of addicts have low rates of HIV infection and because the female-to-male transmission vector is weak. But I can imagine another scenario for Sam that involves exploration of sex with men.

Like David, Sam is more likely to be genuinely unclear about whether incest occurred, so the deathbed story would have great impact on him, probably pushing him to squarely confront the issue of molestation for what may be the first time. The recent stories about priest abuse have helped sexual abuse of boys come out into the open as an issue, but it is still true that estimates are that males are abused at a lower rate than females (Abel & Harlow, 2001) and they are certainly less common users of incest survivor resources. Therefore, Sam could very plausibly have discontinued therapy years before as did Scott, and Sam is arguably even less likely to find support groups for men sexually abused as boys than Scott. So Sam's reaction to what David revealed might activate memories Sam has firmly repressed. Sam, like Scott, is likely to be experiencing full-blown PTSD, as opposed to Sarah and Susan, who likely dealt with their childhood abuse more extensively.

Sam has probably repressed not only memories of possible molestation but also the turmoil that these revelations created in his family 12 years before. His suicidal thoughts may represent a breakthrough into consciousness of fears associated with these incidents, one of which may be that the experiences caused both brothers, not just David, to "turn gay." If Sam has experienced any feelings toward men, this might make him question his sexuality. If his "unsafe sex" is with men, Silverstein will be dealing with serious possibility of HIV transmission and even more prominently, major sexual identity confusion. If Sam is dealing with attractions to men,

however, it bodes well that he chose an explicitly gay therapist. Clearly, Sam intends to confront these fears rather than run from them.

But Sam, like Scott, has probably not received help in resolving these childhood incidents of blurred sexual boundaries and molestation. He is, therefore, very unlikely to define himself as an "incest survivor," and very likely to still have a relationship with both parents that is confused, full of ambivalence, and over-involved rather than distant. Sam's relationship with his parents may be very similar to Scott's: close to Mom, protecting her from Dad, angry and disdainful of his father, but not angry enough at his mother's failure to protect him. It will be very helpful for Silverstein, going forward, to direct Sam to male incest survivor groups, which frequently take place in gay centers, for validation, information, and support. Without this direction, Sam is less likely to find these resources by himself than is Scott.

Among Scott and his three alters, Sam is the least likely to have resolved issues related to childhood molestation. But apart from this, Sam is actually the least likely of the four to experience shame about his sexuality. His first sexual experience was just around the median age for boys, his number of sexual partners, while perhaps a tad high at his age for a heterosexual male, would more likely be a source of pride than shame to him. If his unsafe sex is condomless sex with women, he might be oblivious to his own risk of HIV infection; his concern about not using condoms would be mostly fear of contracting herpes or genital warts or the fear of getting a girl pregnant. He would be less likely to be concerned about being single—30 is still not considered abnormally old for a heterosexual man to be single. If Sam's unsafe sex has been with men, the danger of his behavior needs to be addressed rapidly, as Silverstein did with Scott in the first interview, albeit clumsily.

So the most pressing issues for Sam, besides bereavement, depend on whether he is wrestling with sexual attraction to males. If not, he must finally explore and come to terms with the question of his childhood abuse, and he must find a way to extricate himself from the toxic triangle with his parents. Sam, like Scott, must change his role with his mother and put a stop to his father's financial swindling. Like Scott, Sam's habitual protectiveness of his mother may be augmented by survivor guilt. And, as a straight man, he might have identified more with Dad than did Scott, and that may be a complicating factor in the family dynamic. For example, because of this identification Sam might yearn for an earlier close relationship with his father, or he might be worried that he would "turn out like" Dad. Neither Scott nor Susan or Sarah are as likely to experience these conflicts. And if Sam's "unsafe sex" involves sex with men, then Silverstein will be dealing with sexual identity issues arguably more intense and fraught than those Susan will experience if she is having sex with men. Susan is used to being outside the mainstream, and used to creating communities of support for herself among sexual minorities. Moreover, bisexual women's support groups abound. Thus, it is probably easier to go from lesbian to bisexual woman than from heterosexual man to bi or gay man. Fortunately, if this is what awaits Sam, he had the model of his older brother David to guide him, as well as the best therapist he could have chosen to help.

Summary

As I look at Scott and his alters—these sex and gender permutations—I am struck by the following similarities and differences.

Sarah and Susan have the following in common:

- Similar cultural socialization regarding sexuality;
- Similar experience with an incestuous father;
- Similar cultural pressure to be in a monogamous relationship;
- Similar support systems for sexual abuse;
- Similar likelihood that they have dealt with some of the family issues.

What is most different about them—the way that sexual orientation influences the mix—is that Sarah has enjoyed more mainstream acceptance, even in these days of lesbian chic, and that she has not dealt with the sometimes complex sexual identity issues that Susan has faced, and will be facing again if she is having sex with men. This difference of course cascades to other dynamics, but still, my overall impression is that Sarah and Susan are more alike than different.

Sarah and Sam, however, seem to have much less in common, besides heterosexual mainstream identity and lifestyle. Their reactions to every single aspect of this case that involves sexuality and relationships will most likely be different, sometimes starkly so (e.g., shame about multiple partners versus pride).

Sam and Scott have the following in common:

- Similar likelihood that the alleged sexual abuse was never explored, with all the attendant mental health issues that implies;
- Similarly ambivalent attitudes about whether the abuse ever occurred;
- Because of this, similar family dynamics;
- A similarly unremarkable sexual history, up until the riskiness of the past year;

On the other hand, the differences are significant as well. Heterosexual and gay men represent opposite ends of the risk spectrum for contracting HIV. Sam, like Sarah, has always enjoyed heterosexual privilege. He has not experienced life outside the mainstream, nor the stigma that still results from being gay. Sam is less likely than Scott to feel shame about his sexuality, while Scott may have some sexual shame related to internalized homophobia.

As two gay people, Susan and Scott share a common community, one with better resources for incest survivors—much better for Susan—than are available to their heterosexual counterparts. In fact, in general one of the things shared by both lesbian and gay male culture is a more open, explorative, and nonjudgmental attitude toward most aspects of sexuality. For example, lesbians were among the first women to declare themselves "sex radicals" and question negative attitudes toward pornography, kinky sex, gender bending, and nonmonogamy in the feminist movement (Vance, 1984), and variant sexual practices are taken for granted in the lesbian community (Nichols & Shernoff, 2006). So in general, Scott and Susan both will receive more support for sexual issues of all kinds than will their heterosexual counterparts. And, of course, they both experienced "coming out" issues and the

struggles of being a stigmatized minority (LaSala, 2010). But the gender differences between Scott and Susan outnumber the similarities attendant to their shared sexual orientation. Everything from the meaning of their sexual histories, the likelihood of contracting HIV, the degree of shame connected to sexuality, their likelihood of having worked through the molestation issues, and the relationships they have with their parents would be different for these two gay people.

In the case of "Scott," gender differences trump sexual orientation, and I would argue that this will often be true when there are sexual or romantic relationship issues of a particular kind: those dominated by paternalistic power differentials, sexual issues in which the "double standard" prevails. These issues throw gender differences into high relief while sexual orientation differences are muted. By contrast, a clinical case without sexual issues, or with sexual concerns of a different nature, might show a different kind of pattern.

Imagine Scott's case, and his three alters, without sexual abuse and without any concerns about sexual behavior. There are few ways such a case would vary by gender or sexual orientation. In bereavement, perhaps the males would be more likely to express their grief as irritability and the females as sadness. The women might be more likely to be the parents' caretaker than the males, particularly Sam, the heterosexual male alter. But these are not major differences. A case with no sexual or intimate relationship issues might actually be a gender and orientation-blind case, or the closest we come to it in reality. In that case, not much specialized knowledge of either gender differences or sexual orientation would be required on the part of the therapist; being gay affirmative, for example, might have been sufficient, as opposed to gay-knowledgeable.

Our perceptions of child sexual abuse vary by gender because they stem directly from our general beliefs about the differences between male and female sexuality. We know that males are more sexually active than females in nearly every way and at an earlier age (Laumann et al., 1994). Moreover, men seem more able to separate sex and romantic love than women. It is hard to deny that a cultural double standard still exists, that we reward men for being sexual and punish women for being sexual except under narrowly constrained circumstances, such as when sex is part of a romantic relationship. Anyone who has raised teens of both genders knows this: The sexual behavior my son engaged in to enhance his "reputation" as a teen would lower my adolescent daughter's "reputation."

Upon reflection, I realized that my own initial reaction to Scott's showering story was influenced by gender bias. I thought, "Maybe it *was* innocent. Maybe the boys' discomfort *was* rooted in their early recognition of male-sexual attractions." My doubts about the meaning of the father–son showering led me to have doubts about the deathbed story as well, wondering whether this was a "real" event or a distorted "recovered memory." But when I imagined Sarah and Susan, I had no such thoughts. I felt instinctively that the showering was inappropriate, and that it might indicate greater abuse. David's story seemed more plausible, too: a man who sexually abuses children very often abuses girls and boys alike.

Some of my reaction simply reflected the heterocentric cultural value that it is "okay" for persons of the same sex to be naked in each other's company, but not

for opposite sex children or adults. But there is also gender bias. What is our reaction to the idea of a mother showering with her 7- or 8-year-old son? It makes most of us uncomfortable, and we might think of the mother as "smothering" and "lacking boundaries." But many of us would not automatically think of the mother as a sexual predator, as we might a father who showers with his daughter.

The other sexual issues in this case that make gender differences so salient involve sexual activity and STIs (sexually transmitted infections). Here, the double standard prevails. Heterosexual men brag about, even exaggerate, their sexual exploits. Gay men flaunt their "sluttiness." But few women, gay or straight, can take open pride in having large quantities of sexual partners or sexual activity, and many women see STIs not simply as health problems but as a cause for shame and proof of their "dirtiness."

There are some areas of sexuality where gay men and lesbians are more similar to each other than their heterosexual counterparts. Gay people deal with other gender and sexual variations better than heterosexuals. Among gays and lesbians, especially in urban areas, BDSM and nonmonogamy/polyamory have such high visibility and such a relatively high frequency of occurrence that there is little stigma attached to these forms of sexual behavior. Even bisexuals and transgender people, who confront some discrimination within the gay community, are more easily accepted there than they are within mainstream heterosexual society (Nichols, 1994).

The dynamics of intimate couple relationships vary at times by gender, at other times by sexual orientation. On one hand, considerable research has found that both gay male and lesbian couples are more egalitarian than heterosexual couples (Gottman, 2010; Schwartz, 1994). Gay couples, like heterosexual couples, establish roles within the relationship that may appear similar to heterosexual gender roles. But the roles taken by gay couples lack the consistency usually found in opposite sex pairings: the gay man who does the cooking may be the "top" in bed; the "lipstick lesbian" may be the one who grouts the tile in the bathroom. Moreover, there is no inherent assumption of a power differential that follows gender. An example of this comes from the literature about heterosexual versus gay/lesbian parents. Heterosexual couples leave the bulk of parenting *and* home chores to women, even when both partners are working, thus privileging the father. Gay and lesbian couples share more equal distribution of these tasks, regardless of which partner appears to be more feminine or masculine (APA, 2010; Bryant & Demian, 1994).

On the other hand, there are ways in which same-sex couples seem to exhibit extremes of gender-stereotypic behavior. Gay male couples are frequently successful in negotiating nonmonogamy; perhaps this is because both partners have the male ability to compartmentalize sex. Long-term lesbian couples have arguably less sex than heterosexual or gay male relationships but more affection (Blumstein & Schwartz, 1983; Nichols, 2005); this could be seen as an expression of a female sexual ideal. Another female trait, prioritizing couple relationships, is caricatured in this joke ubiquitous in the gay community: Q: What does a lesbian bring to the second date? A: A U-Haul. Moreover, as Gottman (2010) observes, gay couples

are often more effective in communicating and resolving conflict because, as two males or two females, they "speak the same language."

Of most interest to me are questions that involve the interaction of gender and sexual orientation. For example, based on personal experience, it did not surprise me to learn that researchers had proven gay and lesbian parents to be more egalitarian than heterosexual parents. What I am interested in is how the lesbian and gay parents differ from each other. To the extent that same-sex couples sometimes magnify gender-stereotypic behavior (lesbian cuddling versus gay male nonmonogamy), their behavior can tell us something about male and female behavior when it is unconstrained by someone with opposing role behaviors. For example, lesbian sexual encounters, which typically last longer, involve more nongenital touching, and result in a higher percentage of orgasms than do heterosexual encounters, may represent unrestrained female sexuality, just as gay male nonmonogamy probably represents an ideal for males.

In Scott's case, examples of these intersections of gender and sexual orientation seemed minor. Unless Silverstein deliberately used a stereotype to throw readers off the track of Scott's true identity, his choice of a "creative profession" is one such case. So, to me, was his exceptionally close relationship to his mother, which seems more characteristic of gay men than of heterosexual men. The closeness may have been based solely on the other family dynamics, but it may also stem from Scott's partial identification with his mother as a gender-variant boy.[4]

Scott's case is interesting because at first reading it appears to be "all about" male homosexuality: two gay brothers, a gay therapist, and HIV. But in the end, the gender-related issues surrounding sexual abuse and the cultural double standard regarding sexual behavior may turn out to dominate the problems related to sexual identity, gender trumping orientation just as it frequently does in everyday life.

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[4] If he was gender variant as a child—there is not enough information in this first interview to determine that, and certainly not all gay men were gender variant as children.

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